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6 **BEFORE THE**  
7 **BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS**  
8 **DEPARTMENT OF CONSUMER AFFAIRS**  
9 **STATE OF CALIFORNIA**

10 In the Matter of the Accusation Against:

Case No. VN-2009-185

11 **JANICE KAREN COLE**  
12 **1925 Otay Lakes Road, Apt. 11**  
13 **Chula Vista, CA 91913**

**DEFAULT DECISION AND ORDER**

**Vocational Nurse License No. VN 206305**

[Gov. Code, §11520]

Respondent.

14  
15 **FINDINGS OF FACT**

16 1. On or about January 12, 2011, Complainant Teresa Bello-Jones, J.D., M.S.N., R.N.,  
17 in her official capacity as the Executive Officer of the Board of Vocational Nursing and  
18 Psychiatric Technicians, Department of Consumer Affairs, filed Accusation No. VN-2009-185  
19 against Janice Karen Cole (Respondent) before the Board of Vocational Nursing and Psychiatric  
20 Technicians. (Accusation attached as Exhibit A.)

21 2. On or about September 25, 2003, the Board of Vocational Nursing and Psychiatric  
22 Technicians (Board) issued Vocational Nurse License No. VN 206305 to Respondent. The  
23 Vocational Nurse License expired on November 30, 2010, and has not been renewed. Pursuant to  
24 Business and Professions Code section 118(b), the expiration of Respondent's license does not  
25 deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or  
26 to render a decision imposing discipline on the license.

27 3. On or about January 12, 2011, Respondent was served by Certified and First Class  
28 Mail copies of the Accusation No. VN-2009-185, Statement to Respondent, Notice of Defense,

1 Request for Discovery, and Discovery Statutes (Government Code sections 11507.5, 11507.6,  
2 and 11507.7) at Respondent's address of record which, pursuant to Business and Professions  
3 Code section 136, is required to be reported and maintained with the Board, which was and is:  
4 1925 Otay Lakes Road, Apt. 11, Chula Vista, CA 91913.

5 4. Service of the Accusation was effective as a matter of law under the provisions of  
6 Government Code section 11505, subdivision (c) and/or Business & Professions Code section  
7 124.

8 5. On or about February 1, 2011, the aforementioned documents were returned by the  
9 U.S. Postal Service marked "Unclaimed."

10 6. Government Code section 11506 states, in pertinent part:

11 (c) The respondent shall be entitled to a hearing on the merits if the respondent  
12 files a notice of defense, and the notice shall be deemed a specific denial of all parts  
13 of the accusation not expressly admitted. Failure to file a notice of defense shall  
14 constitute a waiver of respondent's right to a hearing, but the agency in its discretion  
15 may nevertheless grant a hearing.

16 7. Respondent failed to file a Notice of Defense within 15 days after service upon her of  
17 the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. VN-  
18 2009-185.

19 8. California Government Code section 11520 states, in pertinent part:

20 (a) If the respondent either fails to file a notice of defense or to appear at the  
21 hearing, the agency may take action based upon the respondent's express admissions  
22 or upon other evidence and affidavits may be used as evidence without any notice to  
23 respondent.

24 9. Pursuant to its authority under Government Code section 11520, the Board finds  
25 Respondent is in default. The Board will take action without further hearing and, based on the  
26 relevant evidence contained in the Default Decision Evidence Packet in this matter, as well as  
27 taking official notice of all the investigatory reports, exhibits and statements contained therein on  
28 file at the Board's offices regarding the allegations contained in Accusation No. VN-2009-185,  
finds that the charges and allegations in Accusation No. VN-2009-185, are separately and  
severally, found to be true and correct by clear and convincing evidence.

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10. Taking official notice of its own internal records, pursuant to Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for Investigation and Enforcement is \$9,408.00 as of March 15, 2011.

## DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Janice Karen Cole has subjected her Vocational Nurse License No. VN 206305 to discipline.

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Vocational Nursing and Psychiatric Technicians is authorized to revoke Respondent's Vocational Nurse License based upon the following violations alleged in the Accusation which are supported by the evidence contained in the Default Decision Evidence Packet in this case.:

a. Respondent is subject to disciplinary action pursuant to Business and Professions Code (Code) section 2878(a), on the grounds of unprofessional conduct, as defined by Code section 2878.5 (a) in that Respondent obtained, possessed and self administered controlled substances in violation of Code section 4060 and Health and Safety Code section 11173(a) in that on June 25, 2009, Respondent admitted to her doctor that she was abusing methamphetamines and that it had been going on for approximately 10 years. She also admitted to her doctor that she was stealing narcotics from her nursing job at a rehabilitation center, and using the narcotics while she was at work. She told the doctor the narcotics caused her to make medication errors which resulted in her being terminated from her nursing job. On January 3, 2010, Respondent was admitted on an emergency basis to Paradise Valley Hospital for a psychiatric evaluation, the hospital performed a urine drug screen on Respondent, and it was positive for amphetamines, benzodiazepines and alcohol.

b. Respondent is subject to disciplinary action under Code sections 2878(a) and 2878.5(b) on the grounds of unprofessional conduct in that she used controlled substances or dangerous drugs in a manner dangerous to other persons when she stole controlled substances and dangerous drugs from the rehabilitation center, then self-administered

1 those drugs and worked under the influence as a nurse, which caused her to make  
2 medication errors.

3 c. Respondent is subject to disciplinary action under Code section 2878(j) on the  
4 grounds of unprofessional conduct in that Respondent was dishonest when she stole  
5 controlled substances from the rehabilitation center, while she worked there as a nurse.

6 d. Respondent is subject to disciplinary action under Code section 2878.5(e) in that she  
7 falsified, or made grossly incorrect, grossly inconsistent or unintelligible entries in  
8 hospital and patient records pertaining to controlled substances, when she withdrew  
9 medication but failed to chart the administration or wastage of the medication to any  
10 patients at the rehabilitation center from May 3, 2009 to June 22, 2009.

11 e. Respondent is subject to disciplinary action under Code section 2878(a) in that she  
12 failed to safeguard a patient's health when on June 22, 2009, she gave an extra dose of  
13 medication to a patient that was not ordered to be given to the patient.

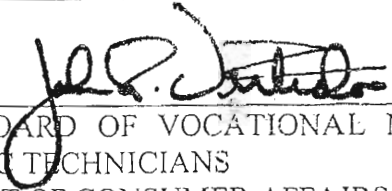
14 ORDER

15 IT IS SO ORDERED that Vocational Nurse License No. VN 206305, heretofore issued to  
16 Respondent Janice Karen Cole, is revoked.

17 Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a  
18 written motion requesting that the Decision be vacated and stating the grounds relied on within  
19 seven (7) days after service of the Decision on Respondent. The agency in its discretion may  
20 vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

21 This Decision shall become effective on May 27, 2011.

22 It is so ORDERED April 27, 2011

23  
24   
25 FOR THE BOARD OF VOCATIONAL NURSING AND  
26 PSYCHIATRIC TECHNICIANS  
27 DEPARTMENT OF CONSUMER AFFAIRS  
28

27 Attachment:  
28 Exhibit A: Accusation

# Exhibit A

Accusation

FILED

JAN 12 2011

Board of Vocational Nursing  
and Psychiatric Technicians

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8  
9 **BEFORE THE**  
**BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS**  
**DEPARTMENT OF CONSUMER AFFAIRS**  
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. VN-2009-185

12 **JANICE KAREN COLE**  
13 1925 Otay Lakes Road, Apt. 11  
14 Chula Vista, CA 91913

**A C C U S A T I O N**

15 Vocational Nurse License No. VN 206305

16 Respondent.

17  
18 Complainant alleges:

19 **PARTIES**

20 1. Teresa Bello-Jones, J.D., M.S.N., R.N. (Complainant) brings this Accusation solely in  
21 her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric  
22 Technicians, Department of Consumer Affairs.

23 2. On or about September 25, 2003, the Board of Vocational Nursing and Psychiatric  
24 Technicians issued Vocational Nurse License Number VN 206305 to Janice Karen Cole  
25 (Respondent). The Vocational Nurse License expired on November 30, 2010, and has not been  
26 renewed.

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## JURISDICTION

3. This Accusation is brought before the Board of Vocational Nursing and Psychiatric Technicians (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2875 of the Code provides, in pertinent part, that the Board may discipline the holder of a vocational nurse license for any reason provided in Article 3 (commencing with section 2875) of the Vocational Nursing Practice Act.

5. Section 118(b) of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated. Under section 2892.1 of the Code, the Board may renew an expired license at any time within four years after the expiration.

## STATUTORY PROVISIONS

6. Section 2878 of the Code states:

The Board may suspend or revoke a license issued under this chapter [the Vocational Nursing Practice Act (Bus. & Prof. Code, 2840, et seq.)] for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

.....

(j) The commission of any act involving dishonesty, when that action is related to the duties and functions of the licensee.

7. Section 2878.5 of the Code states:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Vocational Nursing Practice Act] it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist or podiatrist administer to himself or herself or furnish or administer to another, any controlled substance as defined in Division 10 of the Health and Safety Code, or any dangerous drug as defined in Section 4022.

1 (b) Use any controlled substance as defined in Division 10 of the Health and  
2 Safety Code, or any dangerous drug as defined in Section 4022, or alcoholic  
3 beverages, to an extent or in a manner dangerous or injurious to himself or herself,  
4 any other person, or the public, or to the extent that the use impairs his or her  
5 ability to conduct with safety to the public the practice authorized by his or her  
6 license.

7 . . . .

8 (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible  
9 entries in any hospital, patient, or other record pertaining to narcotics or dangerous  
10 drugs as specified in subdivision (b).

11 8. Section 4060 of the Code states, in pertinent part, that no person shall possess any  
12 controlled substance without a prescription by a physician.

13 9. Section 11173 (a) of the Health and Safety Code provides, in pertinent part, that (a)  
14 no person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure  
15 the administration of or prescription for controlled substances, (1) by fraud, deceit,  
16 misrepresentation, or subterfuge.

#### 17 COSTS

18 10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the  
19 administrative law judge to direct a licensee found to have committed a violation or violations of  
20 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
21 enforcement of the case.

#### 22 DRUGS

23 11. Amphetamines are a Schedule II controlled substance as designated by Health and  
24 Safety Code section 11055(d)(1) and a dangerous drug pursuant to Code section 4022. It has a  
25 pronounced stimulant effect on the central nervous system.

26 12. Benzodiazepines are controlled substances and are a class of drugs used as  
27 antianxiety tranquilizers. The most common side effects are drowsiness, confusion, and loss of  
28 coordination. In combination with alcohol or barbiturates, these effects are addictive.

13 13. Dilaudid is a Schedule II controlled substance as designated by Health and Safety  
14 Code section 11055(b)(1)(k) and a dangerous drug pursuant to Code section 4022. Dilaudid is a  
15 brand name for the generic drug hydromorphone and is used to treat pain.

1 14. Morphine Sulfate is a Schedule II controlled substance as designated by Health and  
2 Safety Code section 11055, subdivision (b)(1)(M), and is a dangerous drug pursuant to Code  
3 section 4022. It is used for pain management.

4 15. Norco is a trade name for the generic drug hydrocodone with acetaminophen which is  
5 designated by Health and Safety Code section 11055(b)(1) as a narcotic drug and a Schedule II  
6 controlled substance, and by Business and Professions Code section 4022 as a dangerous drug. It  
7 is used as a narcotic analgesic in the relief of pain.

8 16. Vicodin is a trade name for the generic drug hydrocodone with acetaminophen  
9 which is designated by Health and Safety Code section 11056(e)(4) as a narcotic drug and a  
10 Schedule III controlled substance, and by Business and Professions Code section 4022 as a  
11 dangerous drug, and is used as a narcotic analgesic in the relief of pain.

#### 12 FIRST CAUSE FOR DISCIPLINE

13 (Unprofessional Conduct - Obtain, Possess and Self-Administer Controlled Substances)

14 17. Respondent is subject to disciplinary action pursuant to Code section 2878(a), on the  
15 grounds of unprofessional conduct, as defined by Code section 2878.5 (a) in that Respondent  
16 obtained, possessed and self administered controlled substances in violation of Code section 4060  
17 and Health and Safety Code section 11173(a). The circumstances are as follows:

18 18. Respondent was employed as a licensed vocational nurse at Lemon Grove Care and  
19 Rehabilitation Center in Lemon Grove, California, from March 26, 2009 to June 25, 2009.

20 19. On or about June 25, 2009, Respondent admitted herself into Alvarado Parkway  
21 Institute, a psychiatric facility, for treatment for her anxiety disorder and suicide ideation. During  
22 the psychiatric intake evaluation, Respondent admitted to her doctor that she was abusing  
23 methamphetamines and that it had been going on for approximately 10 years. She also admitted  
24 to her doctor that she was stealing narcotics from her nursing job at Lemon Grove Care and  
25 Rehabilitation Center, and using the narcotics while she was at work. She told the doctor the  
26 narcotics caused her to make medication errors which resulted in her being terminated from her  
27 nursing job the day before.

1       20. On or about January 3, 2010, Respondent was admitted on an emergency basis to  
2 Paradise Valley Hospital for a psychiatric evaluation. Respondent drank a bottle of whiskey and  
3 then drove herself to the hospital. Respondent told her doctor that for three days she has been  
4 having command hallucinations telling her to kill herself. The hospital performed a urine drug  
5 screen on Respondent and it was positive for amphetamines, benzodiazepines and alcohol.  
6 Respondent admitted to her doctor that in the past, she had used intravenous drugs for six months,  
7 and had stolen those drugs from her work place.

8                               SECOND CAUSE FOR DISCIPLINE

9       (Unprofessional Conduct -Use of a Controlled Substance In a Manner Dangerous to Others)

10       21. Respondent is subject to disciplinary action under Code sections 2878(a) and  
11 2878.5(b) on the grounds of unprofessional conduct in that she used controlled substances or  
12 dangerous drugs in a manner dangerous to other persons when she stole controlled substances and  
13 dangerous drugs from Lemon Grove Care and Rehabilitation Center, then self-administered those  
14 drugs and worked under the influence as a nurse, which caused her to make medication errors.  
15 The facts and circumstances are more specifically set forth in paragraphs 19 and 20 above and 23  
16 through 27 below, and are incorporated herein as though fully referenced.

17                               THIRD CAUSE FOR DISCIPLINE

18       (Unprofessional Conduct - Dishonesty)

19       22. Respondent is subject to disciplinary action under Code section 2878(j) on the  
20 grounds of unprofessional conduct in that Respondent was dishonest when she stole controlled  
21 substances from Lemon Grove Care and Rehabilitation Center, while she worked there as a nurse.  
22 The circumstances are more specifically set forth in paragraphs 19 and 20 above, and  
23 incorporated herein as though fully referenced.

24                               FOURTH CAUSE FOR DISCIPLINE

25       (False, Incorrect or Inconsistent Entries in Hospital/Patient Records)

26       23. Respondent is subject to disciplinary action under Code section 2878.5(e) in that she  
27 falsified, or made grossly incorrect, grossly inconsistent or unintelligible entries in hospital and  
28 patient records pertaining to controlled substances, when she withdrew medication but failed to

1 chart the administration or wastage of the medication to any patients. The circumstances are as  
2 follows:

3 Patient V.M.

4 24. Patient V.M. had a physician's order for 5mg-500mg tablets of Vicodin for pain  
5 management.

6 a. On or about May 25, 2009, at 1600, Respondent withdrew one 5/500mg Vicodin  
7 tablet for Patient V.M. Respondent failed to chart the administration or wastage of this  
8 medication.

9 b. On or about May 31, 2009, at 1230, Respondent withdrew two 5/500mg Vicodin  
10 tablets for Patient V.M. Respondent failed to chart the administration or wastage of this  
11 medication.

12 c. On or about June 10, 2009, at 1400, Respondent withdrew one 5/500mg Vicodin  
13 tablet for Patient V.M. Respondent failed to chart the administration or wastage of this  
14 medication.

15 d. On or about June 11, 2009, at 1500, Respondent withdrew two 5/500mg Vicodin  
16 tablets for Patient V.M. Respondent failed to chart the administration or wastage of this  
17 medication.

18 e. On or about June 12, 2009, at 1500, Respondent withdrew one 5/500mg Vicodin  
19 tablet for Patient V.M. Respondent failed to chart the administration or wastage of this  
20 medication.

21 f. On or about June 13, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin  
22 tablet for Patient V.M. Respondent failed to chart the administration or wastage of this  
23 medication.

24 g. On or about June 15, 2009, at 1930, Respondent withdrew one 5/500mg Vicodin  
25 tablet for Patient V.M. Respondent failed to chart the administration or wastage of this  
26 medication.

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1 h. On or about June 16, 2009, at 2100, Respondent withdrew one 5/500mg Vicodin  
2 tablet for Patient V.M. Respondent failed to account for the tablet of Vicodin and did not chart  
3 the administration or wastage of this medication.

4 i. On or about June 21, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin  
5 tablet for Patient V.M., however Respondent charted that she administered this medication at  
6 1600, one hour before she actually withdrew the medication.

7 j. On or about June 22, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin  
8 tablet for Patient V.M. Respondent failed to chart the administration or wastage of this  
9 medication.

10 k. On or about June 22, 2009, at 2200, Respondent withdrew one 5/500mg Vicodin  
11 tablet for Patient V.M. Respondent failed to chart the administration or wastage of this  
12 medication.

13 Patient V.F.

14 25. Patient V.F. had a physician's order for 5/325mg tablet of Norco (Hydrocodone)  
15 every 6 hours as needed for pain management.

16 a. On or about June 21, 2009, at 1500, Respondent withdrew two 5/325mg  
17 Hydrocodone tablets for Patient V.F. Respondent failed to account for the two Hydrocodone  
18 tablets, by either charting the administration or wastage of the medication.

19 b. On or about June 22, 2009, at 2100, Respondent withdrew one 5/325mg  
20 Hydrocodone tablet for Patient V.F. Respondent failed to account for the Hydrocodone tablet, by  
21 either charting the administration or wastage of the medication.

22 Patient R.M.

23 26. Patient R.M. had a physician's order for 5/500mg tablets of Vicodin (Hydrocodone)  
24 every 6 hours as needed for pain management.

25 a. On or about May 3, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin tablet  
26 for Patient R.M. Respondent failed to chart the administration or wastage of the medication.

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1           b.    On or about May 4, 2009, at 1700, Respondent withdrew two 5/500mg Vicodin  
2 tablets for Patient R.M. Respondent failed to chart the administration or wastage of this  
3 medication.

4           c.    On or about May 13, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin  
5 tablet for Patient R.M. Respondent failed to chart the administration or wastage of the  
6 medication.

7           d.    On or about May 16, 2009, at 1730, Respondent withdrew two 5/500mg Vicodin  
8 tablets for Patient R.M. Respondent failed to chart the administration or wastage of the  
9 medication.

10          e.    On or about May 17, 2009, at 1700, Respondent withdrew two 5/500mg Vicodin  
11 tablets for Patient R.M. Respondent failed to chart the administration or wastage of the  
12 medication.

13          f.    On or about May 24, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin  
14 tablet for Patient R.M. Respondent failed to chart the administration or wastage of the  
15 medication.

16          g.    On or about May 26, 2009, at 1700, Respondent withdrew two 5/500mg Vicodin  
17 tablets for Patient R.M. Respondent failed to chart the administration or wastage of the  
18 medication.

19          h.    On or about May 28, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin  
20 tablet for Patient R.M. Respondent failed to chart the administration or wastage of the  
21 medication.

22          i.    On or about May 29, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin  
23 tablet for Patient R.M. Respondent failed to chart the administration or wastage of the  
24 medication.

25          j.    On or about May 31, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin  
26 tablet for Patient R.M. Respondent failed to chart the administration or wastage of the  
27 medication.

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1 k. On or about June 1, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin tablet  
2 for Patient R.M. Respondent failed to chart the administration or wastage of the medication.

3 l. On or about June 1, 2009, at 2000, Respondent withdrew one 5/500mg Vicodin tablet  
4 for Patient R.M. Respondent failed to chart the administration or wastage of the medication.

5 m. On or about June 5, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin tablet  
6 for Patient R.M. Respondent failed to chart the administration or wastage of the medication.

7 n. On or about June 10, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin  
8 tablet for Patient R.M. Respondent failed to chart the administration or wastage of the  
9 medication.

10 o. On or about June 11, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin  
11 tablet for Patient R.M. Respondent failed to chart the administration or wastage of the  
12 medication.

13 p. On or about June 13, 2009, at 1700, Respondent withdrew two 5/500mg Vicodin  
14 tablets for Patient R.M. Respondent failed to chart the administration or wastage of the  
15 medication.

16 q. On or about June 14, 2009, at 1800, Respondent withdrew one 5/500mg Vicodin  
17 tablet for Patient R.M. Respondent failed to chart the administration or wastage of the  
18 medication.

19 r. On or about June 15, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin  
20 tablet for Patient R.M. Respondent failed to chart the administration or wastage of the  
21 medication.

22 s. On or about June 16, 2009, at 1700, Respondent withdrew two 5/500mg Vicodin  
23 tablets for Patient R.M. Respondent failed to chart the administration or wastage of the  
24 medication.

25 t. On or about June 16, 2009, at 1800, Respondent withdrew two 5/500mg Vicodin  
26 tablets for Patient R.M. Respondent failed to chart the administration or wastage of the  
27 medication.

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1           u.     On or about June 17, 2009, at 1700, Respondent withdrew two 5/500mg Vicodin  
2 tablets for Patient R.M. Respondent failed to chart the administration or wastage of the  
3 medication.

4           v.     On or about June 18, 2009, at 1700, Respondent withdrew one 5/500mg Vicodin  
5 tablet for Patient R.M. Respondent failed to chart the administration or wastage of the  
6 medication.

7           w.     On or about June 19, 2009, at 1700, Respondent withdrew two 5/500mg Vicodin  
8 tablets for Patient R.M. Respondent failed to chart the administration or wastage of the  
9 medication.

10          x.     On or about June 20, 2009, at 1700, Respondent withdrew three 5/500mg Vicodin  
11 tablets for Patient R.M. Respondent failed to chart the administration or wastage of the  
12 medication.

13          y.     On or about June 21, 2009, at 1700, Respondent withdrew two 5/500mg Vicodin  
14 tablets for Patient R.M. Respondent failed to chart the administration or wastage of the  
15 medication.

16          z.     On or about June 22, 2009, at 1700, Respondent withdrew two 5/500mg Vicodin  
17 tablets for Patient R.M. Respondent failed to chart the administration or wastage of the  
18 medication.

19          aa.    On or about June 22, 2009, at 2100, Respondent withdrew three 5/500mg Vicodin  
20 tablets for Patient R.M. Respondent charted the administration of two of the Vicodin tablets, but  
21 failed to chart the administration or wastage of the remaining one tablet of Vicodin.

22           Patient B.M.

23          27.    Patient B.M. had a physician's order for Dilaudid 4mg, as needed for pain.

24          a.     On or about June 11, 2009, at an illegible time, Respondent withdrew one Dilaudid  
25 4mg tablet for Patient B.M. Respondent failed to chart the administration or wastage of the  
26 medication.

27          b.     On or about June 11, 2009, at 2100, Respondent withdrew one Dilaudid 4mg tablet  
28 for Patient B.M. Respondent failed to chart the administration or wastage of the medication.

1 c. On or about June 14, 2009, at an illegible time, Respondent withdrew one Dilaudid  
2 4mg tablet for Patient B.M. Respondent failed to chart the administration or wastage of the  
3 medication.

4 d. On or about June 14, 2009, at 1830, Respondent withdrew one Dilaudid 4mg tablet  
5 for Patient B.M. Respondent failed to chart the administration or wastage of the medication.

6 e. On or about June 15, 2009, at 1400, Respondent withdrew one Dilaudid 4mg tablet  
7 for Patient B.M. Respondent failed to chart the administration or wastage of the medication.

8 f. On or about June 15, 2009, at 1800, Respondent withdrew one Dilaudid 4mg tablet  
9 for Patient B.M. Respondent failed to chart the administration or wastage of the medication.

10 g. On or about June 16, 2009, at 1800, Respondent withdrew one Dilaudid 4mg tablet  
11 for Patient B.M. Respondent failed to chart the administration or wastage of the medication.

12 h. On or about June 19, 2009, at 1400, Respondent withdrew one Dilaudid 4mg tablet  
13 for Patient B.M. Respondent failed to chart the administration or wastage of the medication.

14 i. On or about June 19, 2009, at 2200, Respondent withdrew one Dilaudid 4mg tablet  
15 for Patient B.M. Respondent failed to chart the administration or wastage of the medication.

16 j. On or about June 20, 2009, at 1400, Respondent withdrew one Dilaudid 4mg tablet  
17 for Patient B.M. Respondent failed to chart the administration or wastage of the medication.

18 k. On or about June 20, 2009, at 1700, Respondent withdrew one Dilaudid 4mg tablet  
19 for Patient B.M. Respondent failed to chart the administration or wastage of the medication.

20 l. On or about June 21, 2009, at 1400, Respondent withdrew one Dilaudid 4mg tablet  
21 for Patient B.M. Respondent failed to chart the administration or wastage of the medication.

22 m. On or about June 21, 2009, at 2200, Respondent withdrew one Dilaudid 4mg tablet  
23 for Patient B.M. Respondent failed to chart the administration or wastage of the medication.

24 n. On or about June 22, 2009, at an illegible time, Respondent withdrew one Dilaudid  
25 4mg tablet for Patient B.M. Respondent failed to chart the administration or wastage of the  
26 medication.

27 o. On or about June 22, 2009, at 1400, Respondent withdrew one Dilaudid 4mg tablet  
28 for Patient B.M. Respondent failed to chart the administration or wastage of the medication.

1 p. On or about June 22, 2009, at 2030, Respondent withdrew one Dilaudid 4mg tablet  
2 for Patient B.M. Respondent failed to chart the administration or wastage of the medication.

3 q. On or about June 22, 2009, at 2130, Respondent withdrew one Dilaudid 4mg tablet  
4 for Patient B.M. Respondent failed to chart the administration or wastage of the medication.

#### 5 FIFTH CAUSE FOR DISCIPLINE

##### 6 (Unprofessional Conduct – Failure to Safeguard Client's Health)

7 28. Respondent is subject to disciplinary action under Code section 2878(a) in that she  
8 failed to safeguard a patient's health when she gave an extra dose of medication to a patient that  
9 was not ordered to be given to the patient. The circumstances are as follows:

10 29. On or about June 22, 2009, Respondent incorrectly administered morphine sulfate to  
11 a patient. The doctor's orders were for morphine sulfate 15mg to be administered at 0900 and  
12 1700. Respondent gave the patient a dose of morphine sulfate 15mg at 1700 and 2100. There  
13 was no doctor's order for a dose at 2100 and Respondent was not authorized to administer  
14 medication at that time.

#### 15 AGGRAVATING FACTORS

16 30. Prior to Respondent being licensed by the Board on September 25, 2003, Respondent  
17 was arrested for possession of amphetamines. Respondent was allowed to attend and complete a  
18 diversion program pursuant to Penal Code section 1000. On September 18, 2003, Respondent  
19 received a warning letter from the Board advising her that the Board would not pursue any  
20 disciplinary action against her at that time because she had completed the diversion program but  
21 future similar behavior would result in disciplinary action against her license.

#### 22 PRAYER

23 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
24 and that following the hearing, the Board of Vocational Nursing and Psychiatric Technicians  
25 issue a decision:

26 1. Revoking or suspending Vocational Nurse License Number VN 206305, issued to  
27 Janice Karen Cole;

28 ///

1           2.     Ordering Janice Karen Cole to pay the Board of Vocational Nursing and Psychiatric  
2 Technicians the reasonable costs of the investigation and enforcement of this case, pursuant to  
3 Business and Professions Code section 125.3; and

4           3.     Taking such other and further action as deemed necessary and proper.

5  
6 DATED: January 12, 2011



TERESA BELLO-JONES, J.D., M.S.N., R.N.  
Executive Officer  
Board of Vocational Nursing and Psychiatric Technicians  
Department of Consumer Affairs  
State of California  
*Complainant*

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